BULLETIN

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BULLETIN

Mahoning County Medical Society
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The Bulletin is published nine times a year, monthly with the exception of May, July and August by the Mahoning County Medical Society, 5104 Market Street, Youngstown, Ohio 44512.
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Information

"...computer literacy is a must for the busy practitioner if he wishes to keep abreast of the current medical information flood."

The amount of information targeted toward the physician is increasing at a steady rate. This deluge creates a problem for information perusal, storage and retrieval. The amount of time that can be allocated to reviewing this material is much less than the amount of time needed to utilize it properly.

The number of professional journals for each specialty increases in number as new niches are uncovered by the publishers. Organized medicine at all levels also distributes journals, articles and bulletins to keep the physician current on today's affairs. The regulatory agencies at the state and federal level also bombard the practitioner with new regulations and changes in the old. The ability to keep pace with this information explosion is daunting.

For the busy practitioner to avail himself of the medical library facilities is difficult in a busy schedule. Fortunately, there are increasing numbers of areas that can be accessed from home or the office.

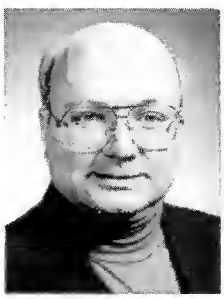
I subscribe to a number of specialty journals which I peruse on arrival and read the articles that appear to be most pertinent at the present time. I have these journals bound at the end of the year and keep them at home. I also receive a yearbook to help focus some of the important areas. My "throw away" publications, I scan and tear out worthwhile articles. I put these aside for later filing. The problem with these methods is retrieval of the desired information. I have a difficult time cataloging the torn out articles and identifying a desired article from the bound volumes.

One method that I have found to be effective for this retrieval is through the GRATEFUL MED computer program from the National Library of Medicine. For a relatively modest fee, the practitioner can access this huge database and search for the desired topics. These retrieved titles can then be located through the medical library or personal volumes. This database is an excellent source for preparing presentations or simply researching a challenging patient condition. The program also allows access to the database for the National Cancer Institute, listing current treatment recommendations and current research protocols. This service is also available through the medical libraries.

A new device for easy retrieval of information is the new CD ROM (Compact Disk Read Only Memory) disks that are now becoming available. These allow tremendous amounts of information to be stored at home and retrieved on the personal computer. These are the same size as audio disks but can contain volumes of static data. The PDR currently is available in such a format. The advantages of this format are readily obvious. The storage space is the size of a CD and not of the book form. Also, the desired drugs can be quickly accessed through the search routine rather than leafing through a large paper volume. As the CD players come into more widespread usage, the cost of these disks should become very low because of the numbers involved. The large medical tests of the future will probably be in this format. The savings in storage space, cost and the easy accessibility of the data will be revolutionizing.

I recently obtained a single CD that has the following: *The American Heritage Dictionary, The World Almanac and Book of Facts, U.S. Zip Code Directory, Bartlett's Familiar Quotations, The Chicago Manual of Style, Roget's Electronic Thesaurus, Business Information Sources*, a spelling verifier and corrector, and certain standard forms and letters. All these on a single CD.

Electronic bulletin boards are also available but to date do not seem as worthwhile



James A. Lambert, MD

as some of the other devices. These are available by specialty society as well as various user groups. The Free Net through YSU has been available for several years but seems to be struggling to find a good use.

The point to be made is that computer literacy is a must for the busy practitioner if he wishes to keep abreast of the current medical information flood. The home computer with its modem access to the world of data will be an increasingly useful tool for the literate physician. This article was written on my computer using a word processor with a spelling checker. Now is a good time to start learning about and using personal computers. □

Mahoning County Medical Society Auxiliary

AMA-ERF Holiday Sharing Card Project

It is time to once again think of sending holiday greeting cards. To remember your friends in the Mahoning County Medical Society during the holidays, the auxiliary is sponsoring a holiday sharing card. This fund raising project is for the American Medical Association Education and Research Foundation (AMA-ERF). Cara Lee has designed a beautiful holiday greeting card which will be sent to each society member and spouse. An enclosure card listing the names of all those who make a donation will be included. We hope you will choose to have your name as part of this list.

By supporting this project you will enjoy the following advantages:

1. *Your AMA-ERF donation is Tax Deductible.*
2. *The holiday sharing card involves no labor on your part. (The committee does all the work.)*
3. *Your special holiday wishes will be conveyed to the members of the Mahoning County Medical Society and Auxiliary.*
4. *Your donation is an investment in the future of good health care in this country.*
5. *You will be performing a service to the auxiliary by helping us to help others.*

Here is the simple procedure to follow: Send me your tax deductible check for as much as you wish. Do it now, before the Christmas rush begins. Please make checks payable to AMA-ERF. The holiday sharing cards will be in the mail by December 10th. Remember, this is a charitable cause and one to which we have a deep commitment. Please be generous and let me hear from you by November 26, 1990.

Sincerely,
Cynthia Hayek, AMA-ERF Chairperson

Mahoning County Medical Society Auxiliary
AMA-ERF Holiday Sharing Card Project

Name(s) to be listed on the card: _____

School to receive contribution: _____

Fund to receive contribution: (check one)
_____ Medical School Excellence Fund
_____ Medical Student Assistance Fund

Signature _____ Date _____

Please make your check payable to **AMA-ERF** and mail with this form to:
Cynthia Hayek, 5840 Everett East Road, Hubbard, Ohio 44425

Changing Medicine

Historically, women have been a minority in the field of medicine. Prior to 1960, they constituted between 7 percent and 8 percent of the medical community. Women also were found in what was considered to be predominantly "female specialties": pediatrics, child psychiatry, psychiatry and anesthesia. In 1974, the percentage of women in medicine was nearly 23 percent and remains at about 25 percent today, although the NEOUCOM class of 1990 was 44 percent women.

"It is difficult for somebody with the demands of today's society to see themselves in practice as are some of the more established physicians."

Many people are concerned about the trend toward more women entering medicine. There is a belief that this trend leads to less office-based practice and promotes the existence of part-time medicine as well as hospital based and HMO practices. Recent statistics seem to bear this out. However, I feel that there is some other input which is missing when evaluating the role of women in shaping medical practice in America.

First, dual career families have now become the norm in American society. I think the practice of medicine has lagged behind because, financially, one person is usually able to stay at home and raise the children, and, typically, that person is the female. When medical students were polled regarding their thoughts for the future, approximately 80 percent of the women expected to marry physicians or professional persons. Likewise, approximately 60 percent of the men expected to marry physicians or professional persons. When then asked about their expectations of contributing to raising a family and home duties, the women expected to share equally in these duties with their spouses, whereas the males expected to contribute less.[1] You can see where a conflict might arise should a male and female physician marry.

Also, approximately 44 percent of the female medical students polled expected to interrupt their career at some point to raise a family. In contrast, only 5 percent of the men expected to interrupt their careers at any point for family duties. If 60 percent of male medical students expect to marry professional women, there is less chance that these women will sacrifice their careers to stay home. We should see some compromise on the time male physicians spend at work vs. home, thus affecting practice choices.

Second, look at the outside influences on medicine. Reimbursement issues, PROs and public antagonism all make the good old country doctor image less real and perhaps less appealing to many young physicians.

Third, there is the issue of role models. Many of the physicians who are presently in practice have done their training prior to 1965. It is difficult for somebody with the demands of today's society to see themselves in practice as are some of the more established physicians. In speaking to the established physicians, one finds that typically they spent long hours during their early careers away from home, in emergency rooms, taking whatever work was available. All the while, their spouse (usually the wife) remained at home steadfastly keeping home and family together.

Today, the spouse may be a working spouse, and there has to be a compromise on physician hours. Women physicians typically put off having children until the end or near the end of training and are unwilling or unable to work the pace of the solo practitioner from years ago.

There are many reasons why medicine is changing, and, certainly, the influx of women into the field of medicine is part of it, but what medicine is facing now, I think, much of the rest of society has faced many years ago with the rise of dual career families. I think this is the issue in changing medicine and not necessarily the increasing number of women in medicine. □

Denise L. Bobovnyik, MD

[1] Bonar, Joy Walker, M.S. "Sex difference in career and family plans of medical students." JAMWA. Nov. 1982: 300-304.

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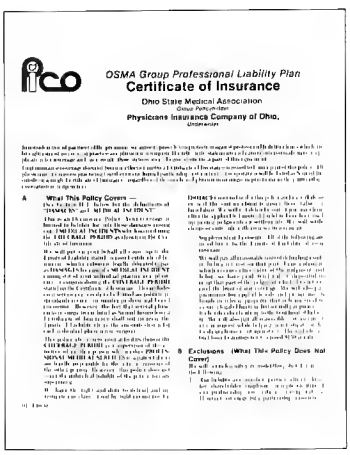

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The Role of the Patient Representative

"Patient representatives have proven in the past 18 years to be one of the physician's best allies in the hospital setting."

The latest survey conducted by the National Society of Patient Representatives of the American Hospital Association revealed that at least two out of every four hospitals employ one or more patient representatives.

Patient representation as a profession and the National Society of Patient Representation are now 18 years old. In the present stage of professionalism, we are passing through our adolescence, experiencing many of the attendant thoughts, feelings and actions that children express during their teen-age years. We explore means of expanding the limits. We try to find realistic answers to questions, i.e., how small we define and measure the quality of service to our patients? How shall we continue our quest for excellence?

Adolescence is a time of growth and change for patient representation, and to quote an ancient Greek philosopher, Heraclitus, "Nothing endures like change." Since change does endure, patient representatives are challenged to manage a protean environment daily.

Patient representatives are expert at relationship management. We are professionals who exert leadership to help our hospitals achieve a high level of customer satisfaction by excelling at managing relationships between patients, families, physicians and hospital employees.

The patient representative functions in multiple roles to include models with different demands and perceptions. The "ombudsman" model implies a different strategic approach than would an "advocate" model. The patient representative as ombudsman seeks to balance the interests of patient, staff and administration in achieving an acceptable compromise to all concerned. Central to the "advocacy" model is the relationship of patient advocate to patient representation. The patient representative represents the patient to administration in seeking problem resolution that is in the best interest of both the patient and the hospital.

There is also the "managerial" model in which the patient representative is a facilitator for change. The primary function of the patient representative in this model is to serve as the "liaison" between patients and the organization as a whole and between the institution and the community it serves. As the institution's direct representative, the patient rep interprets its philosophy, policies, procedures and services to patients, their families and visitors. The patient rep collects data and channels information about patient care problems to appropriate departments and makes recommendations for change in hospital procedures and policies as necessary.

The patient representative evaluates the level of patient satisfaction with the hospital experience. The patient rep also functions as part of the mechanism for investigating patient complaints that may involve the hospital or medical staff and participates in the hospital's risk management program.

The most important customers to the hospital are the physicians and the patients. The physicians are the "gatekeepers" of the health care system. Patient representatives have proven in the past 18 years to be one of the physician's best allies in the hospital setting. Cardiologist Kenneth M. Campione states, "Some doctors may think of patient representatives as primarily allied with the patients against them. Actually they serve as a valuable liaison between the two, and doctors will call on them for assistance a lot more when they understand just how valuable patient reps can be." (From Howard Eisenberg Medical Economics/September 15, 1980 Issue)

An example of the sort of thing Dr. Campione was talking about is defusing liability time bombs. A good patient rep can head off a malpractice suit at the pass. Often the patient rep learns of a malprac-

Nila J. Fuller
Patient Representative
Southside Medical Center

tice danger before the doctor. Many hospitals give patient representatives almost unlimited room for maneuvering to forestall a potential litigation.

Patient reps can be the busy doctor's surrogate listener. Patients will frequently raise issues with patient representatives that they wouldn't dream of discussing with their doctors, even though they may have the highest respect for their doctors.

William Wood, director of Risk Management for the Western Reserve Care System, states, "I perceive the role of the patient representative as an early identification system to resolve things before they get out of hand, also as a means of gathering information in a nonthreatening manner to assist in resolving issues before they evolve to the stage of litigation." Patient representatives work closely with top administration and usually know the system's dead-ends and shortcuts.

According to the most recent survey of the National Society of Patient Representatives of the American Hospital Association, 60 percent of patient representatives have a bachelor's or master's degree; 23 percent have either an associate degree or nursing diploma; and the remaining 17 percent have at least one year of college education. Considering the number of things patient reps do with intelligence, humor and negotiating skills, attending related educational programs on a continual basis ranks very high as a means of keeping current.

If you are a physician with privileges on the medical staff of WRCS and haven't utilized the service of the patient representative, let us prove how valuable we can be. □

A Way, Down $outh in Dixie

Some people head to Florida to work on their tans and golf swings, lightening their wallets considerably in the process. A number of knowledgeable folks, however, head south to save a bundle - by reducing their tax bite. For physicians and other professionals who are retiring or considering considerably slowing down and limiting their practice in Ohio, Florida domicile may be worth considering. There are no state, county or city income taxes in Florida, nor are there any city sales taxes. Additionally, Florida does not impose any state inheritance taxes, and there are relatively low probate costs.

"In order to establish a new domicile, it is necessary to maintain an actual presence in the new state and have the requisite intent to remain there for an indefinite period of time."

To absolutely qualify as a Florida domicile, all you have to do is move to Florida and never come back. Easy, but impractical...More likely that you would like to have your cake and eat it too, being able to live and perhaps work in both states a portion of the year. Even if you retire to Florida, you still may want to keep certain Ohio ties. How can you benefit from Florida's tax system in both instances? Retirees, obviously, should have no problem if they use a little common sense. For the others, there are possibilities, but, as might be expected, it is not as easy as one might hope.

To be subject to Florida's tax system, Florida must be your state of domicile. Contrary to popular belief, the terms "domicile" and "residence" are not synonymous. Domicile means the place where a person has a "true, fixed, permanent home and principal establishment, and to which, whenever ... absent, [a person] has the intention of returning." Sturgeon v. Korte. Your residence, on the other hand, is where you are physically present and live, regardless of intent. To qualify for Florida domicile, while retaining ties locally, one must work towards being able to say, "My home (domicile) is in Florida, but I have a place (residence) in Ohio."

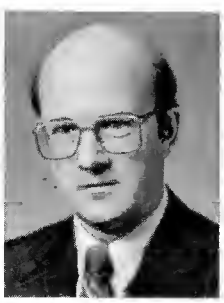
In order to establish a new domicile, it is necessary to maintain an actual presence in the new state and have the requisite intent to remain there for an indefinite period of time. Florida, always interested in attracting out-of-staters, accommodates the move by providing a packet for the establishment of domicile which can be obtained from the Florida Department of Taxation. Once completed, in Florida's mind, it constitutes prima facie evidence of domiciliary status there.

Before rushing off to order your kit, however, read on, for while Florida may eagerly embrace you to its domiciliary bosom, the state of Ohio will be very reluctant to let you, or more accurately, your money, depart.

In order to reap the benefits of a Florida domicile, you must first abandon your Ohio one. If this is not done, you may be deemed to have had two domiciles, and from this flows all manner of woe. (The cases are legion in which a wealthy person dies and more than one state claims the decedent as their own.) Under Ohio law, the burden of proving that a person has abandoned a domicile and has adopted a new one is on the person who asserts the change. Proof of domicile is a question of fact that must be proven by the weight of the evidence. In other words, just because you claim that Florida is your domicile does not mean Ohio will let you off its tax hook.

As a general rule, the courts look at a person's conduct in determining their place of domicile, so what do you do to make that conduct persuasive? There is no set formula. Again, the issue is intent, and common sense would say that each of the following actions are expressive of that intent:

First, file a declaration of domicile in Florida. Obtain a Florida driver's license and license cars in Florida. Use Florida as



Nils P. Johnson, Jr., JD Attorney Johnson is a partner in the Canfield law firm of Johnson and Johnson. He is a contributor to several publications, including Ohio Magazine.

your residence address on documents, such as passport, contracts, deeds and credit cards. Transfer checking and savings accounts to Florida. Register to vote there as well. Sever social ties in Ohio and create new ones in Florida. In this regard, you might want to transfer church or synagogue down south, still attending locally when you are in town. Quit or take inactive status in at least some local clubs.

File your federal tax return from your Florida address. Acquire Florida real estate and sell your Ohio residence, renting instead if you need a place locally. (In this regard, remember that real estate is taxed in the state where it is located, but personal property, such as stocks and bonds, is taxed in the domiciliary state.) It need be noted that you must spend significant time in Florida. Though not determinative of the issue, the Ohio Department of Taxation says that if you continue to keep your home in this state and spend at least four months per year here, you have not abandoned your Ohio domicile and are still subject to Ohio income (and one would suppose, inheritance) tax.

If you perceive these steps as significant life changes, they are. On the other hand, many people in their maturity feel that the savings are worth it.

In sum, to change domicile, there must be a change of residence along with the intent to make the new residence the permanent home. If your individual circumstances will not permit you to change your domicile to Florida at this time, this does not mean that you should not now look into the possibility of doing so in the future. Consult with your estate planner as to whether it would be a good move for you. □

Mahoning County Medical Society Auxiliary

The Mahoning County Medical Society Auxiliary held its annual new members luncheon at the home of Debbie Van Rees. The following prospective new members were introduced: Mary Beth Anbel, Irene Mehle, Monica Houser, Debbie DeMarco, Cathy Ballas, TerriAnn Smith, Kelly Meenan, Renee Sheakoski, Susan Berney, Regina Hennon, Monica Lileas, Maria Cutrona and Nancy Choban. Following the luncheon, President Anita Gestosani conducted a short business meeting. The Auxiliary gave a special thanks to Lady Jade for providing an informal fashion show as entertainment for the event.

This year, as in the past, the Medical Society Auxiliary continues its commitment to volunteerism. Fund-raisers last year provided scholarships for local medical students and grants to the following organizations: The Kidney Foundation, Womens' Crisis Center, Mahoning Valley Food Bank, and the Society for the Blind and Disabled. The Auxiliary provided hands-on volunteer service to the Mahoning County branch of the American Cancer Society.

The 1990-91 program year began with a fashion show and luncheon at Mr.. Anthony's on November 6, 1990. Roberta's of Warren provided the fashions and Lingenfelter-Brill supplied the furs. Shoes were by Richards' of Warren, and Shelley's in the Boardman Plaza furnished the accessories.

The proceeds will benefit the Rescue Ministries to reflect the Auxiliary's desire to assist the homeless of the Mahoning Valley.

On April 12, 1991, the Auxiliary will hold an Art Auction at the Butler Institute of American Art. This event will showcase the works of "local" artists. Revenue from this event will be divided between the Butler and the Rescue Ministries.

Supporting the Auxiliary's Holiday Sharing Card fund-raiser gives members

Anita Gestosani with new members.

and their spouses the opportunity to contribute to the AMA-ERF scholarship fund while wishing the medical community a peaceful and joyous holiday. This year's card was designed by auxiliary member Cara Lee. The word PEACE is beautifully scripted in red and overlays a lone pine tree. The color red symbolizes joy and happiness, and the one word message represents our members' wish for the world. The colorful pine suggests the holiday season. This card has been designed to reflect the Auxiliary's diverse membership.

Another year has begun. Volunteerism, hard work, dedication and friendship are the goals for the Mahoning County Medical Society Auxiliary. Good luck in your year!

☐ Rose Mary Memo

The following applications for membership were approved by Council.

Active:
Glenn H. Kluge, MD
James R. Melloh, MD

First Year:
Steven L. Sheakoski, MD

Second Year:
Shaun Adrian Hennon, MD
Christopher M. Hughes, MD
Alice K. Pomidor, MD

Information pertinent to the applicants should be sent to the Board of Censors by November 27.

AIDS and the Law

The following is a continuation of **AIDS and The Law** which appeared in the September *Bulletin* of the Mahoning County Medical Society.

3. Exceptions to Informed Consent Requirements (O.R.C. Sec. 3701.242) In the following situations, the provisions outlined in the last *Bulletin* regarding informed consent do not apply:
   (a) When the test is performed in a medical emergency by a nurse or physician and the results are medically necessary to avoid or minimize an immediate danger to the health of the patient or another individual. Counseling is required after the emergency is over.
   (b) The test is performed for research and the subject's identity is not known.
   (c) When the test is performed on a deceased individual for purposes of organ donation. (Note: O.R.C. Sec. 3701.246 requires that any human body part donated for transplantation and body fluid donated for transfusion or injection into another person shall be HIV tested, unless recipient waives testing in an emergency situation.)
   (d) When the test is performed by or on the order of a physician who, in the exercise of his professional judgement, determines the test to be necessary for providing diagnosis and treatment to an individual if consent is given to the physician for medical treatment. (Note: Physicians, under O.R.C. Sec. 3701.24, are required to report AIDS cases and positive HIV tests to the Department of Health.) (Note: In each county, one local department of health has also been selected to receive such reports. In this area, reports are to be made to the Youngstown Health Department.)
   (e) When the test is performed after the infection control or similar committee of a healthcare facility determines that a healthcare provider, emergency medical services worker, or peace officer, while rendering health or emergency care to an individual, has sustained a significant exposure to the body fluids of that individual and the individual has refused to give consent for testing.
   (f) The consent of the individual to be tested is not required, and the individual or guardian may not elect to have an anonymous test, when the test is ordered by a court in connection with a criminal investigation.
4. Confidentiality (O.R.C. Sec. 3701.243)
   (a) Except as provided by statute, no person, state or local agency or healthcare provider shall disclose the test results or the identity of any individual who has been tested for and/or is diagnosed as having AIDS. Disclosure is limited to:
   (1) The individual tested, legal guardian or spouse, or sexual partner(s).
   (2) The person to whom disclosure has been authorized by written release.
   (3) The individual's physician.
   (4) The Department of Health, under 3701.24.
   (5) A healthcare provider that handles organ donations.
   (6) A healthcare provider or employee that has a medical need to know for purposes of diagnosis, care and

Neil Altman, MPH
Health Commissioner
City of Youngstown

treatment or for quality assurance and infection control purposes. (Note: Information cannot be requested solely for the purpose of refusing to treat an individual who has AIDS.)

(7) A healthcare provider, emergency medical services worker or peace officer who sustains a significant exposure to the body fluids of another. If the individual was tested pursuant to O.R.C. Sec. 3701.242, the identity of the individual shall not be revealed.

(8) To law enforcement authorities, after obtaining a warrant or subpoena, in connection with a criminal investigation or prosecution.

(b) Not later than 90 days after the effective date of this section, i.e., November 1, 1989, each healthcare facility in the state must establish protocols for the disclosure of AIDS related information. Employees who follow protocol will be immune from liability to any person in a civil action for damages of injury, death or loss to person or property resulting from the disclosure.

5. Court Ordered Disclosure of HIV Test (O.R.C. Sec. 3701.243 [C])

(a) Any person or government agency may seek access to or authority to disclose the HIV test records of an individual:

(1) Action must be brought in the Court of Common Pleas requesting disclosure of or authority to disclose HIV results.

(2) An individual whose results are sought shall be identified by a pseudonym, although the court is to be confidentially notified of the actual name.

(3) An individual whose results are sought shall be entitled to participate in the proceedings which shall be conducted in chambers.

(4) A court order will only be issued if Plaintiff demonstrates a compelling need. The court order will specify who may have access, use of the information and other prohibitions.

(5) Except for an order issued in a criminal prosecution or an order issued through the above procedures, a court shall not order a blood bank, hospital blood center, or blood collection facility to disclose HIV tests performed on voluntary donors in a way that reveals the identity of any donor.

(6) Any disclosure must contain the following or similar language: "This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law." A general authorization for the release of medical or other information is not significant for the purpose of the release of HIV test results or diagnosis. □

POSITION WANTED

I have at present in my employ a superior young woman who has been my main office assistant for six years. She will leave my employ the first of the year, through no fault of her own, but because I shall change my practice pattern. I attest that she is personable, dependable, intelligent, honest, and uses the language quite well. I have found her a very desirable employee, and she will be seeking another position after she leaves. Please feel free to call my office at 726-0022.

Robert B. McConnell, MD

Thomas E. Albani, Jr. MD
Family Practice
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INTERN: Mt. Carmel Medical Ctr, Columbus, OH
REDCY: Mt. Carmel Medical Ctr, Columbus, OH

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Steven L. Balias MD
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MED. ED: Ohio State University, Columbus, OH
INTERN: Ohio State University Hospital, Columbus, OH
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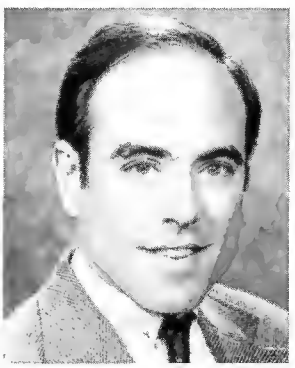

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THE MAHONING COUNTY MEDICAL SOCIETY
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NEOUCOM and Hiram College Establish the Center for Literature, Medicine and the Healthcare Professions

As today's technologies of medical science become more complex and demanding, so do the issues of the human contexts of medicine—the larger ethical, religious and other humanistic realms in which the medical and health care professions function. While medical schools struggle to accommodate the explosion of new clinical knowledge and technologies within a given number of years of professional training, the pragmatic coursework competes for time with coursework in the humanities, and often displaces it. At the same time, there is an increasing awareness of the need for humanities education, especially in the area of health care where human issues pervade day-to-day practice. As Robert Coles, M.D., points out in the *Journal of the American Medical Association*, when he treats a patient with lupus, he has studied and knows how to approach the disease, but his lupus patient also "has a life, a mode of thinking and feeling and seeing and listening and responding that are no one else's, and may count for a lot in how that lupus proceeds."

For Dr. Coles, good literature, such as the stories of William Carlos Williams, brings "to life the everyday hurdles we face in medicine as we struggle not only with our diagnostic and therapeutic challenges, but with ourselves, our inevitably flawed humanity, our times of bitterness or envy or frustration or greed, our passions and dreams, our sometimes extravagant hopes and eager expectations, and, of course (since our patients will one day die, and we as well), our moments of disappointment and melancholy." (JAMA, Oct. 17, 1986, pp. 2125-2126)

To help respond to this recognized need for the humanities, and in particular literature, in health care professions education, Hiram College and Northeastern Ohio Universities College of Medicine have established the Center for Literature, Medicine and the Health Care Professions.

The center will be located on the Hiram campus at the Mahan House, a 19th century Western Reserve home, which will be renovated and restored to original completion.

A $200,000 gift from Alfred Mahan, M.D., and his wife, Marian, of Willoughby Hills, in May, 1990, helped pave the way for the establishment of the center. Mahan was a member of the Hiram Class of 1923.

An Institute for Humanities and Medicine, one of the projects associated with the center, will provide fellowships to 24 humanities faculty and clinical professionals from colleges, universities, medical, nursing and dental schools, and health institutions throughout North America. The institute (the second to be cooperatively directed by Hiram and NEOUCOM) has received funding from the National Endowment of the Humanities totaling $130,000 and will convene between June, 1991, and June, 1992.

The center also will act as a national resource for publications and information on using literature as a vehicle for raising value issues in health care. The center will also serve as a clearinghouse on methods for teaching literature in the professional school and clinical environments.

Martin Kohn, Ph.D., director, Human Values in Medicine and co-director of the center; Delese Wear, Ph.D., program coordinator, Human Values in Medicine, and center co-director Carol Donley, Ph.D., of Hiram, are currently preparing for Kent State University Press an anthology on literature and aging. □.

Martin Kohn, Ph.D.
Center Co-Director

Carol Donley, Ph.D.
Center Co-Director

Third Party Insurance

New Medicare rules make participation the stronger choice.

Though you may be firmly committed against being a medicare participating doctor, it may be a bad economic choice for next year. Your "par or non-par" election comes up in December, so now is the time to evaluate the new facotrs.

When Congress passed the 1989 Omnibus Budget Reconciliation Act ("OBRA") late last year, it included a number of very basic reforms to the way Medicare pays for physician services. We described in our "Perspectives" editorial last April how the proposed new fee schedule starting in 1992 will strikingly affect many doctors. There are, though, some other important changes already getting under way.

Pressure To Go "Par"

Patricia M. Salmon, a principal consultant of The Health Care Group says:

"Many of us expected OBRA to actually mandate participation in Medicare. While it doesn't do that, it creates more problems for 'non-par' doctors which may make switching to 'par' status their better choice."

Nonparticipants' burdens include increasing paperwork and decreasing expected income.

As to paperwork, whether or not you take assignment or participate, you must now complete and submit all claims for your Medicare patients. This requirement went into effect on September 1, 1990, significantly affecting some non-par practices. "It creates a notable new work load for practices submitting claims manually," notes Ms. Salmon, "translating into new and higher costs for them." And it means non-pars will no longer have any paperwork advantage but will still be burdened to bill, rebill and collect their fees.

Worse yet for many non-par doctors, OBRA imposes a new fee ceiling which goes into effect this coming January 1, 1991. The infamous MAAC ("maximum allowable additional charge") will then be replaced by a maximum fee set at 125% of the Medicare - approved fee for the service, generally the so-called Medicare reasonable charge. Ms. Salmon says this new ceiling will usually be less than a non-par doctor's current MAAC, thus lowering what he or she can collect in 1991.

Adding insult to injury, if your current MAAC is *below* the new ceiling you will be limited to that old charge next year – not the full 125% figure – if you remain non-par.

Some state legislatures are making the situation still worse for non-participants. Pennsylvania has just joined Massachusetts in absolutely banning "balance billing" any Medicare patient. This limits a non-par doctor's potential receipt to exactly the same as if he or she participates, plus the problem of billing and collecting it direct form the patient.

December Election

Here's how Ms. Salmon summarizes it:

"It looks like a no-win situation for non-par physicians. And it is clear that, at least for the short term, non-participating doctors will find their Medicare-related income

decreasing. Given the stakes, non-par physicians should critically evaluate the financial impact of that [non-participation] decision."

If you are non-par (our recent Reader Survey showed that 46% of you are), be sure to evaluate the fee picture right away. The next opportunity to change your participation status – for calendar year 1991 – is during the upcoming month of December. We expect many of you will find it preferable to elect "par" status. If you overlook changing your status during December you'll be stuck with your present election for all of 1991.

Test out the old and likely new fee situation for a variety of both your most commonly billed services and your major "big ticket" procedures. If, as we suspect, there will be little dollar advantage in remaining non-par then an election to participate will make business sense.

Ms. Salmon's firm has developed a financial model to help physicians evaluate these factors. It assesses each financial component of the Medicare participation process – from fees to administrative costs – so a practice can gauge the economic effects of par versus non-par in 1991. While not a perfect predictor since not all factors can be known before the year begins, a decision based on sound economic analysis is better than one on purely "gut" feelings.

Be aware, though, that while many practicing doctors are adamant in their opposition to Medicare participation, Congress may finally have pushed them to that economic choice of 1991.

Leif C. Beck
LL.B., C.P.B.C.

Editorial Note: We acknowledge the cooperation of Leif Beck, who has granted reprint rights for topics which have appeared in his regular monthly publication, The Physician's Advisory. His organization, The Health Care Group, with offices in Plymouth Meeting, PA is a group of leading national consultants and attorneys specializing in medical practice organization and management.

The best part of health is fine disposition.
Emerson, the Conduct of Life, 1860

50 Years Ago — November 1940

In 1940, President Roosevelt (FDR) was running for a third term against Wendell Willkie. A page of advertising appeared in the *Vindicator* sponsored by doctors and lawyers who were opposed to a third term. The ad caused a considerable stir. One doctor had a big picture of Willkie in his waiting room, and some patients were so disturbed they got up and left. In the *Bulletin*, the Medical Crier wrote: "We have found that what patients want from us is good medical care, not opinions about how to run the country."

40 Years Ago — November 1950

St. Elizabeth Hospital needed $2 million for construction of a new wing. Dr. F.W. McNamara was named chairman of the committee to solicit the doctors. Dr. Robert Poling was president of the staff. Other physician members of the solicitation committee were William H. Evans, James Birch, Saul Tamarkin, John McCann, Earl Brant and William Allsop.

New members were Ben Brown, Harold Chevlen, George Cook, Frank Gelbman, DeForest Metcalf, E.A Shorten and Dean Stillson. New intern members were Raymond Catoline, Patrick Cestone, Kenneth Hovanic, Frank Inui, Harold Segall and Frank Shaw.

Four member deaths were reported. John R. Buchanan, a popular orthopedist, at the age of 49; Samuel Davidow, a general practitioner; John F. Lindsay, a retired general practitioner; and James Mariner, former health commissioner for the city of Campbell.

Robert R. Fisher, MD

30 Years Ago — November 1960

President Fred Schlecht wrote: "There is considerable pessimism among doctors that domination of (the practice of) medicine by government and pressure groups is inevitable..." How True!

Hugh Bennett was elected president of the Youngstown Area Heart Association. Ray Fenton was appointed Health Commissioner for Mahoning County. "Woody" Metcalf was elected president of the Ohio Society of Anesthesiologists. William Flynn was elected president of the Ohio Division of the American Cancer Society.

20 Years Ago — November 1970

At this time, the big issue was whether the MCMS should participate in the newly formed Mahoning Valley Planning Association. The good news was that the issue was so controversial it brought out 120 members to the meeting. The bad news was that, even with that many members present, the membership couldn't decide what to do. In the end, the members decided to withdraw from participation in the organization. President Robert Jenkins was disappointed. Gene Butcher compared the action of the Society to that of an "ostrich sticking his head in the sand."

Dr. Wendell Bennett was elected into the Curbstone Coaches Hall of Fame. S.Q. Laypius observed: "People seldom sue doctors they love." (He said "seldom.")

10 Years Ago — November 1980

The Mahoning County Medical Society celebrated its 108th birthday on November 13. The first meeting was held on that date in 1872. Federal controls, malpractice suits and deteriorating doctor-patient relationships were looming ever bigger and darker on the horizon. Dr. Frank Gelbman pondered: "I wonder if I am wrong in reluctantly and unhappily concluding that federalization of all medical services is inevitable."

Dr. Chester Lowendorf died of a heart ailment at the age of 76. He was a well-loved orthopedic surgeon who was especially well known for his work with children. □

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AIR FORCE

Lewis K. Reed, M.D., 1909-1990

Dr. Lewis K. Reed, a well-known pioneer in the treatment of alcoholism, was called to his heavenly home on October 24, 1990. Dr. Reed was born almost 81 years ago on January 20, 1909, in Marion, Indiana. Besides a legacy of service, Dr. Reed leaves a son, Dr. David Reed, a member of the Mahoning County Medical Society.

Dr. Lewis K. Reed graduated from South High School, where he was elected to the Honor Society. The caption beneath his senior picture in the South High Annual read: "Ability wins us the esteem of true men." Through academic achievement, a distinguished medical career and active volunteerism, Dr. Reed brought these words to life.

Dr. Reed obtained his pre-medical education at Miami University of Ohio, where he was elected to Phi Beta Kappa. He received his M.D. degree from the School of Medicine at the then Western Reserve University, where he was elected to Alpha Omega Alpha. He served a clerkship in clinical neurology at Boston City Hospital and a three year residency at University Hospitals in Cleveland. Not long after that, the United States became involved in World War II. Dr. Reed joined the Army Medical Corps as a captain in 1942 and was discharged as a lieutenant colonel in 1946.

During his four years in the army, Dr. Reed served with honor as commanding officer and chief of medicine at several U.S. medical facilities. He also served as chief of medical service at the 307th General Hospital in Osaka, Japan.

Dr. Reed was internationally known for his activities in the rehabilitation of alcoholics. He helped to organize many organizations that dealt with alcoholism. In many, he served as president. He was a member of the Youngstown Committee on Alcoholism; Homeless Alcoholics, Inc.; the Alcoholic Clinic of Youngstown; and many other groups. He also served in the OSMA Program for the Impaired Physician and the District Liaison Physician of the AMA Society on Alcoholism. He was in demand throughout the United States and Canada as a speaker on the subject of alcoholism, and he authored or co-authored several papers on alcoholism.

He received many awards, including the Arthur Dobkin Fellowship in 1985 by the Summit County Medical Society; the Bishop Award in 1986 by the Miami University Alumni Association; and the Secod Award in 1987 by the Charter Medical Corporation, Southeastern Conference on Alcohol and Drug Abuse. In 1961, he was made a Kentucky Colonel by then Governor Bert Combs.

Dr. Reed was responsible for the rehabilitation, nationwide, of many physicians and lay persons. He served his country and colleagues well. Whatever he did, he did well, and his deeds and works will live long after him. May he rest in peace. □

Gabriel E. DeCicco, MD

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Music, 1962, oil on canvas, 48" x 60"
by John Koch (1909-1978)

John Koch was born in Toledo, Ohio, in 1910. A self-taught painter, he was educated in Great Britain and France. Koch later set up a summer residence and studio in Paris. A traditional realist-romantic artist, Koch built his reputation on portraits of the prominent art patrons of New York City. "Music" depicts the artist's wife, a well-known New York musician and instructor, in their Manhattan apartment with student Abbey Simon (now a renowned classical pianist) at the piano.

Koch attracted the wealthy elite of New York City to his studio. A financially successful artist, his portraiture created a likeness of the subject which was pleasing aesthetically as well as becoming to the person(s) depicted. The artist posed his subjects within elegant, beautifully lit interiors replete with classical art objects, splendid drapery and decor. Koch taught at the Art Student's League in New York City and was associated with the National Academy of Design. His works are included in the collections of the Butler Institute of American Art, the Art Institute of Chicago, Detroit Institute of Arts, Metropolitan Museum and Museum of Modern Art in New York, the Toledo Museum of Art and in many others collections.

Koch's paintings are reminiscent of the works of seventeenth-century Dutch masters Vermeer, Maes and de Hooch. The soft, misty surfaces and luminous effects in works like "Music" were achieved by underpainting the canvas with egg tempera and glazing in oils. The artist's works were often invited as a part of the Butler's Mid-year Show and were always well-received by the public. "Music" was awarded first purchase prize at the Institute's 1962 Mid-year Show by judges Lawrence Fleischman, a noted collector and art dealer, and Henry Koerner, a well-known artist.

The artist visited Youngstown in the 1970s to paint a portrait from life of William J. Hitchcock, Jr., a prominent area citizen, Butler Institute trustee and generous benefactor of the museum. The completed portrait, a three-quarter length life-size oil on canvas, along with four preliminary pencil studies, came to the Butler for the permanent collection in 1982 as a gift from Mr. and Mrs. George D. Wick of Oklahoma.

Koch died in 1978. □

Albert B. Cinelli, MD, F.A.C.S.

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